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Citation for published version:
Perkins, JE 2024, ''Beware of dalals': A moral world of health market brokerage in Bangladesh', *Journal of the Royal Anthropological Institute*, pp. 1-19. https://doi.org/10.1111/1467-9655.14101

Digital Object Identifier (DOI):
10.1111/1467-9655.14101

Link:
Link to publication record in Edinburgh Research Explorer

Document Version:
Peer reviewed version

Published In:
Journal of the Royal Anthropological Institute

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Download date: 11. Feb. 2024

"Beware of *dalals*": a moral world of health market brokerage in Bangladesh

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Abstract

Anthropological inquiry into brokers and brokerage practice provides a prime entry point for making sense of social change. This article tends to the ways in which the trope of the broker and the everyday practice of those identified as enacting brokerage acts as a linchpin in broader moral grappling in a historical juncture of rapid social change. It draws from the ethnographic context of brokerage discursively constituted and enacted within maternal health markets in Bangladesh, focusing on the trope and actual practice of those identified as morally compromised '*dalals*', brokers bringing women and families from public to private health institutions. It argues the trope of the *dalal* operates as a metaphor for immorality ascribed to morally ambiguous spaces of the private health sector, a way for people to contend with a moral discomfort integral to applying market logics to health services enacted largely outside the jurisdiction of formal regulatory mechanisms. The practice of those identified as embodying *dalals*, in contrast, while flourishing in these conditions, is rooted in economic precarity, primarily of young men with limited power waiting for better opportunities, who negotiate and balance moral and economic imperatives of their line of work.

Introduction

Anthropological fascination with 'the broker' as a type of mediator has a long history in the field. Johan Lindquist (2015a) traces the ebb and flow of this interest since the 1950s, and suggests that 'the broker' remains a vibrant ethnographic entry point for making sense of social change today. A mainstay throughout these undulations is a moral ambivalence of the broker, with some scholars characterising brokers as inherently immoral and manipulative actors, while others see them as heroes in subverting more powerful forces (Piliavsky, 2014). This article tends to the ways in which the trope of 'the broker' and the everyday practice of those identified as enacting particular forms of brokerage acts as a linchpin in broader moral contestation in response to rapid social change, drawing from the ethnographic context of brokerage discursively constituted and enacted within maternal health markets in Bangladesh. Following Johan Lindquist (2015b) and Lisa Bjorkman (2018), this article seeks to make sense of how the valuations of the figure and practice of the *dalal,* a form of broker in Bangladesh, in the maternal health terrain at this particular historical juncture are related to broader shifts within social, institutional and moral terrains.

Bangladesh, like other countries in the global South, has experienced a recent and rapid proliferation of a formal private health sector. The expansion of this market as a social form has reconfigured the terrain of biomedical maternal health service delivery. This reconfiguration has been marked by a sense of moral ambiguity in national policymaking, programming and academic circles. While recognised as providing needed and desired biomedical health services and resources in a biomedical landscape in which these are otherwise scarce, this sector also is noted for its potential to expand exploitation and compromise the quality of health care (Rahman, 2007, Rahman, 2022, Sikder et al., 2015). These national discourses broadly mirror global discourses which tend to display moral unease with applying market logics to health service delivery (see e.g., Mulligan, 2016, Maskovsky, 2000, Rylko-Bauer and Farmer, 2002). In Bangladesh, moral concerns are exacerbated by the minimal state oversight of this sector, with the most recent regulatory framework dating to 1982 (Government of Bangladesh, 1982). This framework is widely viewed as mismatched to the contemporary context of a health market which, now double

the size of the public health sector, outmatches the states capacity to enforce regulatory measures.

In policy, programming, and academic circles, these moral concerns have reached a fever pitch in relation to maternal health, in response to recent findings of national quantitative surveys indicating that rates of surgical birth have skyrocketed, from 12% of all births in 2010 (NIPORT et al., 2012) to 45% in 2022 (NIPORT and ICF, 2023). Such rates are well over the World Health Organization (WHO) estimation of 10-15% of births requiring life-saving surgical intervention (Betran et al., 2016), and are generally understood as driven by the private health sector, with most (84%) caesarean births occurring in private health facilities and most (83%) private facility births conducted surgically (NIPORT and ICF, 2023). That these shifts occurred alongside a stalled reduction in maternal mortality (Hossain et al., 2023) resulted in national outcry articulated as morel panic related to the gratuitous overuse of the caesarean procedures, reflected, for example, in the national “Stop Unnecessary C-section” campaign (Rahman and Chaudhury, 2020). Within these discourses, private facility actors tend to be represented as carrying out unwarranted procedures in the interest of maximising profits according to capitalist logics, and women as demanding such procedures to avoid the pain or inconveniences associated with vaginal childbirth.

Against the backdrop of these transformations and contest, this article illuminates a corner of informal livelihoods sustained through the for-profit maternal health service market, focusing on those identified as morally ambiguous '*dalals*', brokers bringing women and families from public to private health institutions. Though far from bounded within the health service delivery landscape*, dalals* as a discursive figure occupy an indissoluble fixture within it and discourse around *dalals* is immanent to debates around the private health delivery sector in Bangladesh. In practice, and despite formal prohibition, young men identified as *dalals* are omnipresent within public health settings, linking people attending public health facilities with private maternal health services (see Figure 1).

This article explores the figure of the *dalal* as a peculiar form of brokerage in a historical juncture marked by transformations toward health markets, and the schisms between this figure and the everyday practice of young men identified as

embodying this figure. The trope of the *dalal* operates as a metaphor for immorality ascribed to morally ambiguous spaces of the private health sector, a way for people to contend with a moral discomfort integral to applying market logics to health services enacted largely outside the jurisdiction of formal regulatory mechanisms. The practice of those identified as embodying *dalals*, in contrast, while flourishing within these conditions, is rooted in economic precarity, primarily of young men with limited power waiting for better opportunities, who negotiate and balance moral and economic imperatives of their line of work.

Methodology

This article is based on data I generated during 18 months of ethnographic fieldwork in Bangladesh between September 2019 and March 2021 for my doctoral research. During fieldwork, I engaged in participant observation and conducted interviews in various maternal health settings, including maternal health policymaking and programming circles in Dhaka and government and private facilities in Kushtia district, located in the west of the country alongside the Indian border. In Kushtia, I initiated fieldwork in public maternal health settings, spending time with women and formal health service providers in antenatal care corners and labour and delivery rooms of the *upazila* health complexes. However, my focus soon expanded to incorporate private health facilities. I began spending more time with informal actors operating in biomedical health settings, including *ayas*, non-clinical 'helping hands' who support health service providers in various tasks, and eventually young men who people identify as *'dalals'*. In the morning, these young men populated the waiting rooms and courtyards of public health facilities. By the afternoon, I was more likely to run into them in private clinics or diagnostic centres.

When I started frequenting in the *upazila* health complexes, these young men were mostly invisible to me, blending in with the crowds of patients in the outpatient waiting room, easily passing as either patients or their companions. Given the *dalal* discourse to which I had become accustomed in Dhaka described later, I was perhaps expecting to see nefarious-looking individuals embodying this trope. As I grew more accustomed to these spaces, their presence and workings emerged as mundane. Rather than hidden in these shadows, these young men with familiar faces were visible and a common feature in the social mix of the waiting rooms. When patient flow was slow, they chattered amongst themselves in the corners.

Other times they exchanged pleasantries with health service providers, suggesting friendliness and familiarity, or amicably approached different groups of people, who chatted opening and comfortably with them.

Just as these young men became familiar to me, my research assistant, Tamanna, a young researcher from Dhaka, and I simultaneously became familiar to them. Soon, many would greet us when we visited the different complexes. In early mornings, they, like us, were simply waiting for people to arrive. In these quiet moments, we found them open and eager to talk to us and share their stories, as they were also curious to know about us and what had brought a foreigner (*bideshi*) and young urban woman to their social world.

Conjuring the figure of the *dalal*

Figure 1 (about here): Painting on the wall outside of Daulotpurt Upazila Health Complex labour and delivery room reading "Beware of dalals who pick up on patients". Source: Photograph by author

"Beware of *dalals* who pick up on patients" (*Rugi dhorar dalal hote shabdhan*). These painted red words mark the walls of the Daulotpur *Upazila* Health Complex, a sub-district hospital in Kushtia district, ominous. These warnings take as their object the mythical brokers of private health care facilities who loiter at public facilities to intercept people from presumably free of charge services in the public health facilities to privately delivered services in the health market outside the upazila health complex gates. This signage alerts an imagined 'victim' at every turn in the building: the outpatient waiting room, the entry to the labour and delivery room, and throughout corridors. Such literal writing on the wall cautions visitors in all Kushtia upazila health complexes. A blue sign in Bheremara complex reads, "Beware of *dalals* and deceivers (*Dalal o protarok hote shabdhan),*" a perspicuous coupling of deception with the *dalal* figure. These visual markers evoke a contemptible, self-interested trope. Although rarely featuring in official policy, in informal discursive practice among policymakers, development practitioners, health service providers and managers, this figure emerges as deceiving people away from a public health system which (officially) offers 'necessary' services for nominal user fees to a private

health sector, where possibly ‘unnecessary’ services will be obtained at a (potentially exploitative) cost.

While the trope of the *dalal* has a long history in Bangladesh (which I turn to later), and is not a new figure within the health sector, the particular private health landscape they are imagined sweeping people to is. The constitution of Bangladesh committed the government to delivering medical care to people living in rural areas, in the interest of reducing inequities between people residing in urban and rural areas (People's Republic of Bangladesh, 1972). In the decades since independence in 1971, this commitment materialised in a network of public health facilities, with district hospitals, *upazila* (sub-district) health complexes, and union-level facilities forming the scaffolding of this network throughout sub-national settings. In peri-urban and rural areas, until quite recently, such facilities were many people’s primary space for obtaining biomedical maternal health services. However, this public health sector was (and is) generally experienced as fragmented and unreliable, with numerous challenges to maintaining staff and services (Ahmed et al., 2015).

Despite a long-standing ideological commitment to a private health care market underpinned by market-centric ideologies infusing international development practice in Bangladesh (Vaughan et al., 2000, World Bank, 1993), it is only recently that social, economic and political forces conjoined to trigger a proliferation of an institutionalised private biomedical health sector. Over the course of the past two decades, the therapeutic landscape has transformed through a wave of private health facilities, from large corporate hospitals and their satellites to small entrepreneurial start-ups. In 2007, according to official records, hospital beds in for-profit private health facilities represented less than half of those registered in the public facilities (16,105 vs 32,941) (Government of the People's Republic of Bangladesh, 2007), with most of these located in urban spaces (Baru, 2003). Within less than a decade, hospital beds in the for-profit private sector surpassed the number located in the public sector by over 60% (78,246 vs 48,934) (Government of the People's Republic of Bangladesh, 2016). The number of registered private hospitals and clinics quadrupled during the same period, from 1,005 to 4,596 (Government of the People's Republic of Bangladesh, 2007, Government of the People's Republic of Bangladesh, 2016). While discursive practices tends to treat private health sector expansion as an overwhelmingly urban phenomenon (see e.g.

Sattar, 2021), such representations fail to capture the pervasiveness of private health institutions in peri-urban and rural areas today.

Perhaps in no area of health have these new market-based possibilities been more transformative than in maternal health. While as late as 2004, fewer than 10% of women gave birth in a health facility, by 2022 this rate had shot up to nearly 65%. This shift was driven toward birth in private health institutions, with the proportion of births in public institutions remaining steady at fewer than 1 in 5 (NIPORT and ICF, 2023). This has transformed not only the location of birth, but also the very mode of birth, as mentioned in the introduction. Indeed, caesarean birth is a mainstay of procedures offered in even the smallest of clinics I became acquainted with in rural Kushtia, often delivering a handful of basic services. In contrast, few public health facilities provide caesarean services.

Nationally, policymakers and programmers have met these shifts with ambivalence. National policy and strategy documents mention people’s swelling reliance on the private health sector, but treat it as a peripheral entity, a somewhat unwieldy potential ‘partner’ (Government of Bangladesh, 2016). They evoke the poor quality of private sector services, the unregulated costs, and the burden on service users (Government of Bangladesh, 2017). These narratives are magnified in the case of caesarean, where moral panic around ‘unnecessary’ caesarean has come to dominate in policy and programming circles.

In contrast to predominant discourses in Dhaka, in peri-urban and rural Kushtia, women rarely spoke of the potential of availing surgical birth in the interest of conveniences or pain. To the contrary, my research participants acknowledged the potential of this mode of birth to propel new forms of financial or physical inconvenience or long-term pain. However, this technology, for them, was inscribed with the promise of a lifesaving panacea, particularly for the baby. For these women, who were all too familiar with the sometimes-mortal risks of pregnancy and childbirth—most having experienced the death of their own child or having seen a loved one pass away or lose their child as a result of pregnancy or childbirth—caesarean offered a biomedical answer to a life transition increasingly viewed in biomedically risky terms. Ultrasound, which now almost all women (95%) undergo at least once during pregnancy and which women are more likely to seek out than

routine antenatal care (88% are estimated to do so) (NIPORT and ICF, 2023), was articulated by my interlocutors as primarily valuable in its function of foretelling the mode of birth, i.e., whether there was an indication that caesarean would be preferable to a vaginal birth.

Women and their families imagined the private health sector, in its manifold materialisations, as the space for fulfilling aspirations of access to these biomedical technologies. In contrast to public health settings—none of the *upazila* health complexes offered caesarean and the district hospital only reliably did so between 10 am and 2 pm, and ultrasound was provided rarely and intermittently—private health facilities reliably provided these technologies. While women described desires to seek antenatal care and access related free-of-charge resources, such as iron folate through the public health services, they tended to describe public health facilities as offering little over that of a homebirth, since they were not able to access caesarean there. To this point, my interlocuters often described birth aspirations or prior experiences in which they would first try to give birth vaginally at home, but if there were any problem, they would seek out biomedical care in a private facility, where they knew a caesarean birth would be nearly inevitable.

The private maternal therapeutic landscape in Kushtia is a formidable space to navigate. Prices of services vary widely, as do clinical enactments. In rural areas, entrepreneurs seek to cut costs in service delivery, which they view as necessary to place services within reach of their often-poor clientele. Common practices I encountered included staffing facilities with informally trained health workers, relying on rotating surgeons to perform surgical procedures, and foregoing the presence of an anaesthesiologist, relying instead on the performing surgeon or informally trained staff to administer analgesic. Many clinics run without a current license and describe the licensing procedures as a primarily political exercise of appeasing local politicians. With few ‘external’ possibilities for assessing the quality of care or the costs, my interlocutors described leveraging social relationships to maximise their access to better quality services at more affordable prices.

It is within this moment of transformation—and the moral concern it has engendered—that a particular rendering of the figure of the *dalal* is warned against on the walls of the *upazila* health complexes. *Dalals* are not new within these

settings and occasionally appear in scholarly and development documents as a problematic presence in public health facilities (SIDA, 2009, Adams et al., 2019). When translated into English, these discourses privilege the term “broker”, and, indeed, the figure of the *dalal* to which the upazila health complex walls allude is situated within a broader social world of brokerage.

A large body of social science scholarship explores the ubiquitous and nebulous practice of brokerage in different world regions. Thomas Bierschenk, drawing on Geertz (Geertz, 1978), describes the 'paradigmatic' practice of brokerage as occurring within a 'bazaar economy', an economy which functions according to market principles but within a highly unequal distribution of knowledge. Those engaging in brokerage practice exploit the space of knowledge differentials between parties for personal benefit (Bierschenk, 2021). Brokers tend to be written about as powerful actors even as they lack legitimacy, which Akhil Gupta points to as reflecting their position of trying to translate between potentially ‘incompatible’ moral universes (Gupta, 2005). Brokerage is fluid and shifts as social contexts open and close opportunities and demands for different forms of practice (Goodhand and Walton, 2022).

Social science scholarship of South Asia recognises brokerage as a ubiquitous and manifesting in various forms as morally ambiguous intermediaries stand as gate-keepers between people and desired opportunities, services and resources (see i.e., Piliavsky, 2014, Björkman, 2021, Huberman, 2010). While much of this work is concentrated in India focusing on brokerage as a pervasive aspect of engagements with the state (Gupta, 2005, Ansari and Chambers, 2022), such brokerage is also a ubiquitous feature of the social landscape in Bangladesh.

While brokerage in its many forms operates as morally ambiguous, in Bangladeshi discursive practice, brokerage enacted by *dalals* evokes particularly negative connotations rooted in historical contingencies. Here, the *dalal* figure is imagined as an immoral actor, the term isomorphic with deception and betrayal. Nusrat Sabina Chowdhury points to the Independence War of 1971 as the moment when the figure of *dalal* figure crystallised as a traitor. In this historical context, the term *dalal* was employed to insinuate Bengali-origin co-conspirators of the Pakistani state who fought against the establishment of an independent Bangladesh. These

traitors sought to thwart pro-independence efforts as they passed information to the Pakistanis in exchange for financial remuneration (Chowdhury, 2019:128). During this historical moment, the figure of the *dalal* was reified as an antagonist opposed to other protagonist categories in the fight for independence (Chowdhury, 2019:132). Following independence, the term was used throughout indictment proceedings of accused traitors. Within these discourses, *dalals* work in shadows to conspire with the enemy against friends and neighbours for individual gain. Today, it is not uncommon to hear the term *dalal* used in popular discourse to attack a person's character.

In popular and political discourse, *dalals* are imagined as pervasive in various areas of social life, including as gatekeepers to administrative services (Shibli, 2020), facilitators (or not) of migration (Munier, 2021), and price-setters in agriculture (Correspondent, 2019), where they are discursively constituted as powerful and problematic. As is typically the case with brokerage (though not exclusively as Ansari and Chambers (2022) point out), the *dalal* is imagined as a masculine figure.

While not written into official health policy narratives, the discursive figure of the *dalal* emerges prominently in discourses regarding the private health sector in Bangladesh. In Dhaka, policymakers and programmers alike bemoan *dalals,* also referred to as the English term 'agent'. Actors within these spheres imagine *dalals* as those who draw unwitting patients from free-of-charge public health services (also the site of many development initiatives) to financially exploitative and sometimes unnecessary private health services. In these unofficial narratives among national policy and development practitioners, *dalals* work through the art of deception to convince potential consumers that they need something that they do not, including an expensive surgical birth. While *dalals* may not be as nefarious as other 'problematic' categories of men, such as gangsters (*mustaans*) who are conceptualised as operating within networks of organised crime and perpetrating violence (Jackman, 2019, Devine, 2007), as profiteers of their deceptions, the figure of the *dalal* is discursively constituted as immoral.

Soon after arriving in Dhaka, I met with a former president of the Obstetrics and Gynaecology Society of Bangladesh (OGSB), the powerful professional body representing the interests of obstetricians and gynaecologists in the country. On a

Thursday night, I made my way through the viscous Dhaka traffic to Dhanmondi, where she maintains her private chamber in one of many skyscraping private hospitals located in this business centre. The revelation of the exploding caesarean birth rate/stagnating maternal death juxtaposition (National Institute of Population Research and Training (NIPORT) et al., 2017) turned the spotlight on a squirming OGSB, an easy culprit. Thrown into defence, OGSB embarked on an awkward dance of apparent collaboration with public efforts to reduce surgical birth rates in the country.

"C-section is high," the former president of OBSB concedes when I finally have a chance to sit at her desk at around 11 pm following the slew of patients. "But it is not always the fault of the obstetrician," she says. First and foremost, she says, it is attributable to women, educated women in particular, who demand surgical birth. She then explains, "Another bad thing is that there are some syndicates at the community level. And there are some agents, agents with the private clinics and with the grassroots level health workers. And these grassroots-level health workers, they are the first contact point of the pregnant women. And they are also acting as an agent for the private clinics. And these private clinics, many of the private clinics in the rural areas, they have no labour room, they have no midwives, no nurses. They [women] are transferred from home to the OT (operating theatre). There is labour going; she will be in the OT. Because they do not keep any labour room." Given her loyalties, it is perhaps unsurprising that she blames the bloated surgical birth rates in the country squarely on the private health sector and the 'agents' who bring them there. On the one hand, she may appear to be criticising the private sector for not prioritising vaginal birth. However, the broader critique here seems to be about who benefits from the private health market morally (i.e., the doctors) and who benefits less morally (i.e., syndicates, agents and private clinics, presumably owners who seek to profit by only offering lucrative caesarean birth).

The former president's comments illustrate several standard features of the whispered discourses around *dalals/*agents in Dhaka. In these narratives, the agents benefit from the commodification of surgical childbirth, if not 'unnecessarily', then at least in 'non-medically indicated' fashion. She also illustrates the nebulous nature of the agents (or *dalals*), in this case, blurred with the categories of grassroots health workers, the cadres of community-based health workers integral to the Bangladeshi

rural health landscape. Doctors are conspicuously invisible in her narrative as she moves directly from the ‘agents’ to the operating theatre, effacing the doctors who animate them. As their representative, her erasure of doctors is perhaps understandable. Still, her statements reflect a tendency among my interlocutors to gloss over an implication of medical doctors.

Instead, these narratives often frame doctors as ‘victims’ at the hands of the *dalals*. A member of the icddr,b team told me of his obstetrician wife as she worked to initiate a private practice early in her career. After she completed her postgraduation and entered the ranks of the Bangladesh Civil Service, he leveraged his social connections to secure her an enviable position in a Dhaka-based government hospital. However, facing the fierce competition of an inundated private health care landscape in the capital, she travelled to Manikganj, a neighbouring district, to Dhaka every weekend to practice privately while slowly building a clientele base in the capital.

When she arrived, the clinic *maliks,* owners, instructed her to invest in relationships with the *dalals*. The *dalals* are the most powerful link between the villages and the clinics, they told her, and they determine which doctors will have clients and which will not. It does not matter the quality of the doctors' work; if they 'oil' the *dalals* and pay them their cut when they bring clients, the *dalal* will inform the villagers that the doctor is good and bring clients to that doctor. The doctor will have more clients, and consequently, the clinic—ultimately, everybody wins, according to owners. If the doctor does not do this, the *dalals* will say that the doctor is not good, and the doctor will have no clients, to the detriment of both the doctor and the *maliks*.

The injunction morally repulsed my friend's wife. Why should a *dalal* benefit from doing 'nothing', in contrast to the productive work undertaken by doctors? They were deceptive in bringing clients not based on the quality of care but on the kickback provided. In the account, she staked her moral high ground and refused to engage in the practice. I do not know whether she ultimately relented, and it would be uncouth to ask. Despite the common understanding that this is widespread, no medical doctor openly admits to working with *dalals*. To do so would not only equate to an admission of morally ambiguous practice but also hurt one's pride. If doctors

provide quality care, the logic goes, this practice should speak for itself; a good doctor should not need to engage in '*dalal* practice'.

However, this account illustrates the imagined power of the mythical *dalal* figure to make or break doctors and thus the potential for doctors' emasculation at their hands. It also highlights the immorality of advancing one's professional career in this manner. The widespread simultaneous dual practice of medical doctors in public and private health sectors is a normalised practice that only occasionally comes under scrutiny. Some studies suggest that dual practice of physicians in Bangladesh is among the highest in the world, estimating that 80% of public clinicians engage in private practice (Gruen et al., 2002, Berman and Cuizon, 2004). It was common knowledge among my research participants in both Dhaka and Kushtia that doctors use their public practice to build a private clientele. While building a private practice by leveraging one's public practice or one's social network was not generally considered immoral, working with a *dalal* was deemed neither moral nor respectable. This highlights the divisions between perceptions of those who benefit more or less morally from private health markets, despite analogous enactments.

These narratives of *dalals* circulating among doctors and development workers in the biomedical health delivery landscape cohere with the somewhat mythical figure of the *dalal* in Bangladesh and other contexts outside health service delivery. Standard features of this figure include secret operation and using other positionalities to veil work as a *dalal.* They operate through informal power structures and threaten to upset deeply engrained social hierarchies. Furthermore, and perhaps most critically, they generate personal benefit through arts of deception at the expense of individuals represented as unsuspecting ‘victims’. But what does brokerage work look like from the viewpoint of those perceived of as embodying *dalals* in practice? In the following section, I turn to an examination of the everyday operations of those identified as *dalals* in public health facilities.

Operating as a *dalal*

In contrast to these discourses, in public health settings in Kushtia, those identified in embodying *dalals* are hardly secretive. They are easy to spot in the upazila health complex waiting rooms: young men, often wearing modern casual clothing, stonewashed jeans, faded name-brand t-shirts, faux-leather jackets. They are distinct from other men in this setting, those who accompany patients or are

patients themselves and stand purposefully in lines waiting for a doctor's attention. Sometimes the young men huddle and chat, each keeping one eye on the crowds milling through the waiting room. When they spot a person wandering aimlessly, perhaps holding a white prescription paper, one may take leave from their group and approach. With a bit of luck, a young man embodying a *dalal* will leave with a potential patient by 1 pm, when the waiting room clears out, and the health care providers close their workstations for the day in the government facility.

In the outpatient room of Daulotpur upazila health complex, Hassan roams the outpatient waiting room. He hovers just outside the antenatal care (ANC) corner, near the wall where the painted red print warns patients to beware of *dalals* and deceivers. He scans the room and stands near the open door where the midwife rotates women through ANC visits. He strains to overhear what the midwife suggests for their care. When the women exit the room, he waits for the right moment and then approaches and suggests different services they may benefit from at Al-Arafa Diagnostic Centre located down the road.

Hassan is a familiar face in the Daulotpur upazila health complex. A stout young man no older than 25, he greets me and Tamanna each time we enter the Daulotpur outpatient building. Typically, we briefly exchange pleasantries and then head on our way to spend time with the midwives or to talk to the pregnant women. However, the waiting room is practically empty one winter morning. Hassan, like us, loiters and waits for pregnant women to appear through the gates. He lights up and readily agrees when we ask him to tell us his story.

Though garrulous, he talks in hushed tones as he recounts his story of tumbling into this line of work, certainly not what he planned for himself as a university student in engineering. After he obtained his diploma, he planned to enter the Bangladesh Civil Service. Unfortunately, tragedy struck when it came time for him to undertake the rigorous studies required to pursue this path. His mother passed away suddenly, an event which set dominoes of troubles tumbling into motion. His father soon remarried, and he and his stepmother struggled to establish a relationship. The stress-induced by this strain damaged Hassan's neurological health and brought on stress-triggered fainting episodes. Unable to handle the stress, he abandoned his ambitions to pursue the Bangladesh Civil Service. Instead,

he took up a job in a national company in Comilla, on the other side of the country. However, his neurological problems continued, and forced him to abandon his employment.

He returned home to Daulotpur and sought comfort in religion, striving to become a pious man. He grew a *dari,* beard, a mark of piety among Muslim men, and attended mosque regularly to perform *namaj,* prayers. One day while performing *namaj*, he spotted another man with a *dari.* He recognised this man as Sojib Islam, one of the sub-assistant community medical officers (SACMOs) working in the upazila health complex in Daulotpur. Hassan presumed that since he was meeting him in the mosque and Sojib also maintained a *dari*, perhaps he was a good man. He approached him, explained his situation and appealed for his assistance to find a job. Sojib Islam listened and instructed him to come to the upazila health complex in the next couple of days; he would see what he could do. Hassan felt optimistic that Sojib would arrange something for him at the *upazila* health complex. However, when Hassan met Sojib at the complex, the SACMO introduced him to the *malik* of Meyerhashi Clinic and Diagnostic Centre, a private clinic located a couple hundred meters away from the *upazila* health complex. The *malik* agreed to take him on to work bringing people to the clinic (i.e. as a *dalal*) and doing some basic assistance work, such as handing tools to the surgeon during a caesarean, in the clinic. While this arrangement worked well initially, the *malik* eventually learned of Hassan's neurological problems. He said that he could not keep him because he could not do the assistance work in the operating theatre. Hassan soon found a job in Al-Arafa Diagnostic Centre, located about the same distance down the road from the upazila health complex in the opposite direction, where he brings patients for services to this day.

So, what exactly is your designation with Al-Arafa? we ask. *"*To tell you the truth," he says, "the people call us *dalals*; the work we do is like a *dalal* (*manushta dake dalali bole; amar kaj dalalir moto).*" He does not try to sugar-coat it, like many young men in his same line of work do, although he just barely steers clear of using a word as derogatory as *dalal* to refer to himself. His primary responsibility is to bring people to the diagnostic centre for health tests. He does not have a fixed salary; instead, he gets a 20% cut of the fees that the people whom he brings to the centre pay for the diagnostic services.

He is not proud of the work. "All of this work is not good (*Ei shob kaj kamta bhalo na),*" he says, but he tries to do it as honestly as possible. How does he attract people to the diagnostic centre? He tells them that he can offer a 30% discount if they seek services through him at the diagnostic centre. The SACMOs and the medical officers, whom Hassan refers to as the 'sirs', and honorific to signal their position of power compared to him, have relationships with the men operating in the practice of *dalals*, and sometimes the sirs will recommend that people seek tests that they do not need so that these young men can take them for the services, he says. "They will pretend that the people need the test, and they prescribe them some tests like that (*Ei jonno porikkha phon kore, kichu porikkha dei)*." Hassan does not like working that way, he says. He would prefer finding more honest (*shotota*) work. In the meantime, he always tries to do his *namaj* and be honest (*shot*) as far as possible. He maintains a delicate balance in the effort to negotiate the moral ambiguity of his line of work. Religious practice serves as a salve and allows him to maintain moral integrity while responding to economic imperative through the only means he currently sees as available to him. Compounding his moral dissonance, he will not be able to get married before he secures a more reliable income. He asks us to pray for him (*doya kora*) to find a better job.

Narratives around *dalals* seek to disconnect this figure from the social worlds they are integral to, from the private health clinic owners and service providers who charge them to bring patients to their doors, and from the health service providers who work in concert with them. While health service providers and managers speak of the dalals with derision, the visible amicability between the health service providers and the actual people identified as the embodiment of these discursive figures belies this discursive contempt. In contrast, Hassan's experience demonstrates how entangled these social worlds are and how small a piece the work of those enacting the practice of *dalals* is.

However, the category of *dalals* and those enacting these narratives are perhaps the easiest scapegoats. Those who exclusively engage in the work of *dalals* tend to be those with the fewest options available to them. They are often young men like Hassan, who have few other avenues due to life's circumstances, or young men who left school early for one reason or another. Though they are well aware of the discourses identifying them as *dalals,* they are much more likely to describe

themselves in long-form as someone who brings patients to clinics or diagnostic centres. While the young men performing this type of work struggle with its moral ambiguity, it is justified by economic necessity and livelihood ambitions when they have few other opportunities. Still, as the most vulnerable component of this system, the category of *dalals* comprises an easy target for attributing immorality.

This enactment of *dalals,* exclusively masculine in Kushtia upazila health complexes, must also be understood within the context of broader negotiations of youth masculinities in South Asia within formidable political-economic context. Craig Jeffrey describes the unemployment of educated young men in India as a product of globalisation (Jeffrey, 2010b). He describes large categories of young men who pursued the the promises of education but were unable to secure reliable livelihoods thereafter within a context of economic reform and precarity. They therefore find themselves in the space of waiting (Jeffrey, 2010a). He and other and other scholars demonstrate the possibilities which brokerage opens for unemployed young men 'in waiting', focusing on the social forms these take within the practice of political brokerage (Jeffrey, 2010b: 135-170, De Vries, 2002, Hoffman, 2004, Hansen, 1996).

Those operating as *dalals* in the health service terrain in Kushtia can be understood as among young men in South Asia existing within a liminal space of precarity and waiting. For Hassan, engaging in the work of a *dalal* is not the end he imagines for himself, but rather a temporary fix given the failure of the promise of education to open better opportunities. While he attributes this at least in part to the neurological problems he encountered upon his mother's death, he finds himself one among many such young men with limited opportunities, and the private health care market offers a space to bide the time hoping that something better will come along. For women with limited opportunities, the private health market provides a space for claiming informal and semi-formal livelihoods as *ayas,* helping hands, or *sisters*, informally trained nurses. For men without formal biomedical education, opportunities for economic engagement are more likely to be found among the highest tiers as clinic owners, for those with existing social or economic capital, or among its lowest ranks as representatives acting as *dalals.*

In the upazila complexes in Kushtia, young men operating as *dalals* function as analogous to other categories of people facilitating movement of people from

public to private health facilities and often in collaboration with them. However, rather than power in shadows, *dalals* operate among the most vulnerable of these actors, relying only on this line of work in their engagements with the private health sector. Offering up a scapegoat in the trope of the *dalal* turns attention away from other forms of bridging from public to private facilities. Sustaining the trope of the *dalal* as both distinct from other forms of bridging is socially significant. It opens up the possibility to, at once, grapple with moral ambiguity related to the private sector while simultaneously offering cover to allow fluid movement between public and private sectors by other actors.

Indeed, in the *upazila* health complexes it is only the *dalals* warned about on the walls. In the next section, I turn to the everyday interactions between health service users with those embodying *dalals* in public health settings.

Dalals as *porichito* (acquaintances): linking to better care

In Kushtia, the sheer number of private facilities that deliver biomedical maternal health care services and the variations in quality and prices create a maternal health landscape that defies sensibilities of 'rational choice' presumed by capitalist discourses. Among my interlocutors in rural private health facilities, clinic managers and staff described attracting potential clients primarily based on personal relationships rather than competition based on improved clinical quality at more affordable prices. Concomitantly, women and their families rarely spoke of the quality of services as the driving force towards a particular clinic. Rather, they described the centrality of having a *porichito*, an acquaintance, of the clinic, in the quest for obtaining good health care, both in terms of clinical attention and interpersonal interactions, and in influencing the cost of the services. As one of my interlocutors explained, “If you go anywhere [to a health facility], if you go with someone familiar to that place (*manusher porichito to she jaigai hoile*), then everything will be a little bit better.” This maps on to the deeply rooted practices in Bangladesh of leveraging social networks to access desired resources and opportunities.

Thus, the *porichito* assumes a critical place as a linkage to health services through the private health sector. Almost without exception, when women discuss how they decided to go to a particular clinic, it is based on a personal relationship. In many cases the person that served as a link is specifically named. This relation could be a brother (*bhai*), an aunt (*khala),* a traditional birth attendant (*dai*), or a

village doctor (*polli chikitshok*). When this person is a bit more distant or occupies a more nebulous relationship, the person was often described as a *porichito*. In the absence of other relationships, a young man acting as a *dalal* may serve this function.

On another visit to the Daulotpur upazila health complex, the waiting room teeming. Hassan approaches a well-dressed couple; the woman is holding a baby. They chat for a moment, and then he moves on. He approaches a woman named Robina, to whom Tamanna and I spoke earlier in the morning. She visited the midwife, but she is now looking for a doctor to get a prescription. He smiles as she hands him her *kagoj*, papers. He scrutinises them then points toward the waiting room exit. They part ways. Hassan approaches us and takes a seat. We ask what he discussed with Robina. He proposed some tests, he tells us, and also an ultrasound at Al-Arafa Diagnostic, offering her a discount. She does not have money with her today, so she agreed to return on Saturday. He doubts she will return, however. She mentioned that she knows someone from another diagnostic centre, a *porichito*, acquaintance. He presumes she will go to the other diagnostic centre with the *porichito.*

While economic interests may be the primary motivator for those enacting *dalal* practice in public health spaces, they engage with people to establish relationships with them and assist them in various ways to navigate the often-perplexing public health sector where women and their families more commonly express encountering disregard. Consider the following scene from a upazila health complex in Khoksha upazila health complex: It is around 11 am on a Thursday morning. Patients mill about in the waiting room. A sole midwife provides services for pregnant women, one SACMO sees children, but there is no medical officer. Three young men identifiable as *dalals* stand by the open window next to the IMCI corner. Sunbeams pour over them as they laugh amongst themselves. Several mothers balance babies on their hips, a couple of fathers stand nearby, waiting to see the SACMO. One of the three young men ventures from his posse and approaches a baby on a woman's hip. He makes funny face—the baby squeals in delight as his mother smiles.

Another young man embodying a *dalal*, wearing stonewashed jeans and sandals, a large brown shawl wrapped around his shoulders, approaches a small group of people. Where is the *daktar*? one woman complains. It must be because it is Thursday, she says, an insinuation that since it is the day before the Friday holiday, the doctor has decided not to come and take a long weekend. She shakes her head. I will not come back here on a Thursday, she proclaims. The young man in stonewashed jeans approaches the group, a small plastic bag of peanuts in hand. He chats casually with the group as he shells the peanuts and pops them in his mouth. A small older woman approaches him and shows him her ticket. Where is she supposed to go? she asks. He looks over her white paper. Room number six, he responds and points her in the direction. She shuffles on her way.

A medical officer, the young and charming dental surgeon posted at to the upazila health complex as a medical officer to provide general health services, finally appears and struts through the waiting room. He casually greets the young man in the stonewashed jeans, disregarding those who await him, and unlocks the door. The crowd rushes to form a line in front of the door. The young man stands next to them and cracks peanut shells. He cracks some jokes I cannot overhear and the people in the line laugh. “Why is there no female doctor?” complains a woman in a long coral head scarf. The young man responds that there are female doctors nearby, just not in the *upazila* health complex. It is a simple matter of spending a bit of money if she wants to see one. The woman holds her ground in the line.

The young man surveys the line, composed of seven women and two men. Why are there no separate lines for women and men? he muses aloud. The women look around nervously. *Bhai*, he says to the men, keep a bit of distance. He gestures for them to move back, and the men follow his instructions. The young man throws a peanut shell in the tall metal garbage can.

Such is a typical scene in upazila health complex waiting rooms. Despite the signs on the walls trying to delegitimise them as deceivers, young men operating as *dalals* are a perpetual and visible presence. While their intentions are market-oriented, they also assist people to navigate the interior of the public health system, not only to move outside it. This is similar to roles played by other informal actors in the public health system. Zaman and van der Geest (2020) write of ward boys,

cleaners and gatemen of a Bangladeshi public hospital as ‘brokers’ who provide critical mediation in the relationships between health service providers and patients, and assist patients to navigate the confusing context of the public health facility. While young men working as *dalals* in this form are not imaged as internal to the social fabric of the public health complex, they also attend to people’s needs in this setting. Moreover, they can lead people to access the services simply not available in the public health setting.

For those without other links to private health service facilities, people identified as *dalals* may offer social connections supporting women and their families to materialise their aspirations for biomedical health services through the private health market. Sitting on the cold benches in the Daulotpur upazila complex one day, Tamanna and I watch as one woman weaves her way through the crowd of people, pausing to talk with a few of the young men identifiable as *dalals.* Eventually, she takes a seat not far from us. We scoot near her and tell her that we noticed her talking to the men. Could we ask what she discussed with them? Without any visible embarrassment, she tells us that her pregnant daughter needs some services, some basic tests and an ultrasound, so she was making her rounds to try to negotiate the best deal in a private diagnostic centre.

While capitalist logics presume that market forces will naturally reduce the cost of health services (again, while simultaneously improving their quality), the arbitrariness of cost-setting in this health care market precludes such an operation. Just as if you know someone, 'the care will be just a bit better,' women believe that if you know someone, the cost will most likely be less. Without knowing someone, such hopes evaporate. In the absence of other connections, young men like Hassan offer women and families a *porichito* who they believe may assist them in securing better care at a better price.

In tracing migrant journeys through central America, Wendy Vogt observea that while discourse attempted to villainise 'smugglers,' in practice, people related to and engaged with actors identified as such in nuanced ways (Vogt, 2018: 99-100). Similarly, in contrast to the trope of the *dalal*, women and families engage with those operating as *dalals* in nuanced ways, including as an extension of *porichito*. Indeed, *dalals* map onto a broader social world that prioritises social connections to access

resources. Of course, just as Jonathan Parry notes in people's engagement with '*dalals*' to acquire public employment in India, such engagements are not necessarily marked by trust (Parry, 2000:36). Indeed, such relationships may result disappointment. However, for those who have no other recourse, that is to say, no other personal attachments to the private health care landscape, those who embody *dalals* may be a last-ditch effort to access care that is thought to be 'just a little bit better' and just a little bit less expensive.

Conclusion

Embedded within the practice of patronage, the figure of the 'broker' is ubiquitous throughout South Asia, appearing in myriad forms and contexts (Piliavsky, 2014, Berenschot, 2014, Huberman, 2010, Jeffrey, 2010a). In Bangladesh, brokerage remains a permanent fixture of bureaucracy in the shadows. It is common for people to speak of contracting brokers to lubricate bureaucratic navigations and access artefacts as essential as passports and driver's licenses. This type of brokerage is understood as both ubiquitous and morally ambiguous, though a sort of necessary evil to access resources and opportunities. The trope of the *dalal* is uniquely imagined as the worst type of broker in this setting, a deceiver working in the shadows as a traitor.

In Bangladesh, 'brokerage' as it appears in the '*dalal*' trope and '*dalal'* practice is elucidative of broader social, political and economic contingencies (Björkman, 2018) in this moment of rapid transformations in maternal health service delivery defined by medicalisation and commodification. As demonstrated, these transformations have led to a moral grappling regarding how health services should be delivered, by whom, and, indeed, who should benefit from their commodification. Although formal regulatory measures are never totatalising, a basic tenet of political and legal anthropology, regulatory instruments can set boundaries for fields of practice and provide a normative ethical frameworks (see e.g., Roitman, 2005, Moore, 1978), A scarcity of formal regulatory mechanisms defining expected human behaviours within the private health sector in Bangladesh contributes to a flourishing of moral concerns.

Within such conditions, it is perhaps unsurprising that the trope of the *dalal* has come to feature prominently within the more general grappling of policymakers, programmers, and medical professionals. Indeed, the private sector delivers much

that is desired, in the form of material biomedical services for women and families and economic potentialities for health service actors, from medical doctors to those considered by them to be *dalals.* The fantasy of the *dalal* stands in as a representation of the immorality associated with the morally ambiguous private health sector, without needing to point to the immorality of the private health sector in general.

Investigating the trope of *dalals* emerging in political movements against multinational corporations, Nusrat Sabina Chowdhury writes of the power of the *dalal* figure as residing in its ability to confuse and collapse binaries of "local/foreign, friend/enemy, or neighbour/*dalal*" (Chowdhury, 2019:133). This analysis extends this logic, demonstrating how in Kushtia and concerning the private health sector, *dalal* practice assumes a diametric function to this, serving as a linchpin in maintaining boundaries already collapsed: the public/private divide of health service delivery. On the one hand, directing attention to the figure of the dalal serves as a smokescreen to facilitate the fluidity between private and public sectors, from which doctors (licitly) and other health service providers (illicitly) and those with other titles benefit. While these public/private crossovers are functionally analogous, only *dalals* are uniquely imagined as fundamentally immoral in these narratives, a narrative device which serves to discursively constitute these nebulous boundaries.

Set against this trope, the everyday practice of those identified as *dalals* in Kushtia public health spaces appears paradoxically banal. Despite the warnings on the walls, young men identified as embodying *dalals,* trying to make a living in a challenging political-economic context for whom economic opportunities are scarce, perform openly to make contact with patients to link them to private health services. Similarly disregarding the warnings, women and families engage openly with them as they navigate a sinuous new world of maternal health services, where these young men might extend social networks to access desired health technologies.

Note on Contributor

Janet Perkins is a postdoctoral research fellow in the Department of Social Anthropology at the University of Edinburgh. Her research focuses on the interfaces of health care technologies and commodification of health care, and how these reshape medico-social worlds, particularly in South Asia.

Acknowledgements

This project was only possible thanks to many collaborators who shaped my thinking and supported and participated in my data generation. I acknowledge Dr Jeevan Sharman and Dr Lucy Lowe for their support and guidance throughout the project and for providing feedback on this manuscript. I would like to acknowledge my research assistant, Tamanna Majid, for her dedicated and tireless assistance, as well as her always valuable insights. I would like to thank Dr Shams El Arifeen of icddr,b for his support to my fieldwork and Dr Ahmed Ehsanur Rahman of icddr,b, for integrating me into his team and facilitating my access to people and spaces for this project. Finally, I would like to acknowledge all of the women and men who welcomed me into their lives and allowed me to share in their stories. This project received financial support from the Tweedie Exploration Fellowship grant. I obtained institutional ethical approval for this project through the University of Edinburgh School of Social and Political Science (approval date: 29 April 2019) and in-county through the ethical review committee of the International Center for Diarrhoeal Disease Research, Bangladesh (icddr,b) in Dhaka (approval date: 13 November 2019).

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